Weill Cornell Medicine	**Policy Title**	Clinical Documentation – Copy & Paste Restriction in the Electronic Medical Record
	Policy Number	CPO-C 400.61
	Department	Clinical Compliance
	Effective Date	September 2014
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	Approved By	Clinical Compliance Committee
	Approval Date	

Policy

It is WCM policy that (EMR) copy and paste functions shall be used by WCM workforce members appropriately. All medical records entries created with any use of such functionality must be verified by the authoring clinician before finalization to ensure the accuracy of data for the date of service. Copying and pasting shall be done judiciously and with the goal of producing a concise and accurate current day's patient note.

Appropriate use of copy and paste includes the following:

- Copy and paste are generally restricted to content from the author's previous notes. WCM workforce members should refrain from copying and pasting from another clinician's note without appropriate attribution or significant updates to avoid plagiarism and fraudulent billing.

- The content of all notes must accurately reflect the specific date of service relevant information, including the history, exam, medical decision making, counseling, coordination of care, diagnostic testing, treatment, and/or procedure performed.

- The copying of information from one patient record to a different patient's records is prohibited.

- It can be necessary to copy and paste or copy forward, data from within the medical record that is intended to be shared and is easily accessible without significant system navigation. Standard shared content that is generally relative to the overall assessment and care of the patient may include medication lists, allergy lists, social history, family history, past medical history, recently documented review of systems and cumulated history statements and problem lists.

- WCM workforce members shall not re-enter previously recorded data or data that is readily available within the medical record. WCM workforce members are encouraged to cite and summarize applicable lab data, pathology, radiology results, and other pertinent results, rather than copy such reports in their entirety into progress notes and other documentation. The entry must be referenced with the date of the original data that were summarized or cited.

- The specific note elements that are determinants used to support the billed service code must not be cloned. The following are examples of specific note elements that shall not be copied and pasted without free-text editing and updating by the WCM workforce member to make it specific to the date of service. This can be accomplished by updating the date and by free text entering of an attestation of review (indicating no change) and attributing the entry to the date it was copied from:

    - Evaluation and Management Services – Medical Decision Making
    - Evaluation and Management Services – Time Attestation
    - Psychotherapy Services – Long- and Short-Term Goals
    - Psychotherapy Services – Time Attestation
    - Office Based Procedure Services – Clinical Indication, Procedure Detail, Units of Drug Administered
    - Telehealth Criteria – Consent, Modality, Patient Location, Provider Location, Parties Participating, and Time
    - Teaching Physician Attestations
    - Supervision Attestations (Incident To)
    - Scribe Attestations and associated Physician Statement Accepting the Scribe Documentation

Purpose

WCM workforce members are required to document all services rendered in the medical record. The electronic capabilities of all documentation systems must be used appropriately to maintain the reliability of each patient's medical record.

Medical record documentation must adhere to established policies, including but not limited to New York Presbyterian Hospital (NYP) Bylaws, Joint Commission Organization (JCO) requirements, NYP Graduate Medical Education Policies, and Center for Medicare and Medicaid Services (CMS) regulations.

All medical record documentation (as a component of the legal health record) is subject to audit by external regulatory agencies of the federal and state government such as Medicare, Medicaid, the Office of the Inspector General, the State Attorney General's Office as well as third party payers and external peer review organizations. Routine internal auditing of EMR documentation will occur and may be conducted by Quality Assurance and Risk Management, Billing Compliance, IT security and/or Health Information Management personnel. The goal of internal audits is to ensure the adequacy, timeliness, completeness and appropriate authentication of documentation within the EMR.

Excessive use of the copy and paste functionality within the EMR may result in extraneous, unnecessary, and repetitive content that makes the medical record less succinct and more difficult and time consuming to read, and unless carefully edited may result in erroneous documentation of the current service.

Scope

This policy applies to all Weill Cornell Medicine (WCM) workforce members who document in the electronic medical record (EMR) as it relates to documentation, coding, and billing.

Definitions

Copy and Paste - the act of duplicating selected content from a previously completed note and inserting it into a new note. The source note is left in its original state.

Cut and Paste - the act of removing selected content from a previously completed note and re-inserting it into a new note. The source note is altered through the deletion of text that is removed. This is PROHIBITED.

Copy Forward - functionality that is programmed to allow specific content to routinely be brought forward and placed into a new note, without altering the content of any previously completed note.

Cloned Note - a medical record entry created by copying and pasting previously recorded information from a prior note into a new note and not updating or editing the copied entry in the new note which results in identical entries. Cloned notes also result from using (Epic) SmartBlock functionality without updating or editing the note content. Cloned documentation lacks the patient and date specific information necessary to support services rendered to the patient. This can affect the quality of care and can cause improper payments due to false information about the services provided to the patient.

Procedure

WCM workforce members are required to document in compliance with all federal and state laws and NYP and WCM policies and procedures.

The signer of each note is responsible for entirety of the note's content and must ensure that any copied information is a factual reflection of the care provided on that date of service. This includes co-signatories assuming responsibility for entries made to the note by other members of the care team.

WCM workforce members are responsible for correcting any errors identified within their documentation. If an error is identified from a previous note, the workforce member should specify the correction in his/her new note and via addendum in the original note.

A medical record encounter note/entry is considered finalized by the billing provider's act of authentication which is accomplished by their electronic signature and dating of the medical record note.

During the internal auditing processes of provider billing records, the CPO may use the Epic "hover for details" and "audit trail" tools or side-by-side comparison of notes to determine to what extent the billing provider

personally documented date specific entries into the note. Audit findings will be cited for cloned note elements that are determinants used to support the billed service code.

Compliance with this Policy

The Compliance Department will review on an annual basis and update this Policy as needed.

Contact Information

References

Ensuring Proper Use of Electronic Health Record Features and Capabilities

https://www.cms.gov/files/document/ehrdecisiontable062816pdf

Policy Approval

Version History

Original Policy: Electronic Medical Record Guidelines

Current Version: Extracted from the original policy and updated.

Date	Author	Revisions
		Initial draft completed. Original date of issue.